Kentucky Crime Victims Compensation Board
130 Brighton Park Blvd., Frankfort, KY 40601

HIV POST-EXPOSURE *INITIAL* EXAM / TREATMENT BILLING FORM

To be entered by CVCB

CVCB case #_____

Patient Name: _____

Phone Number: _____

City/County where assault occurred: _____ Assault Date:_____

Attention authorized medical personnel administering treatment or service: check box for each service rendered.
Fax completed forms and <u>itemized bills</u> to (502) 573-4817.
For information, call the Crime Victims Compensation Board: (502) 573-2290 / (800) 469-2120.

Initial Exam: Patient Account #

Category	*Cost Reimbursement*	*Rendered*
Labs (Rapid HIV, CBC, CMP)	$150	

As the medical personnel authorized by KRS 216B.400 to perform sexual assault exams, I certify completion of the above checked category.

_____
Printed Name Signature

_____
Facility (Payee) Address Phone # Federal ID #

Medication: Patient Account #

Category	*Cost Reimbursement*	*Rendered*
7-day meds starter pack	$200	
Anti-nausea (28 days)	$30	

I certify completion of the above checked categories.

_____
Printed Name Signature

_____
Facility (Payee) Address Phone # Federal ID #

KRS 346.200(9) No charge shall be made to the victim for sexual assault examinations by the hospital, the sexual assault examination facility, the physician, the pharmacist or health department , the sexual assault nurse examiner, the victim's insurance carrier, or the Commonwealth.

I authorize the release of this information to KY Crime Victim Compensation Board for billing purposes.

_____ _____
Patient Signature Date